

Date: _____ Initials of Staff _____

New Patient Intake Form- Clinics

Patient Name: _____ Gender: M F Birth Date: _____
Address: _____ City/State: _____ Zip: _____ County: _____
Phone Number: _____ May we leave a message? YES NO
Guardian/Power of Attorney: _____ Relationship: _____ Phone: _____
Emergency Contact: _____ Relationship _____ Phone: _____

DOCTOR PREFERENCE:

- FAMILY MEDICINE: Preferred:
- INTERNAL MEDICINE: Preferred:
- PSYCHIATRY – Info on back

CLINIC LOCATION PREFERENCE:

- CRESTON LENOX MT. AYR CORNING

MEDICAL INFORMATION:

Past Doctor/Clinic: _____ City/Address/Phone: _____
Reason for Changing: _____
Current Health Concerns: _____
Chronic Illnesses/Continuing Medical Conditions: _____

Are you under the treatment of any specialty providers? _____ Specialty? _____

Surgeries in Last 3 Year: _____
Medications: _____

Current Pharmacies: _____
Are you currently Active Military? Yes No

OB CURRENTLY PREGNANT: LAST MENSTRUAL PERIOD:

Number of Pregnancies: _____ Number of Living Children: _____ Prior C-sections? NO YES
Issues with past pregnancies: _____ City/Address/Phone: _____

Current OB Doctor: _____
City/Address/Phone: _____
Reason for Change: _____
PCP: _____ Appt Needed? Yes No Sent to Phone Nurse: _____ Answered Pt to VM Date/Time _____
Patient notified of Decision via: Phone Voicemail By: _____ Date/Time _____

PHI Released _____

MRN: _____

Date: _____ Initials of Staff _____

Patient Name: _____ Gender: M F Birth Date: _____

Address: _____ City/State: _____ Zip: _____ County: _____

Phone Number: _____ May we leave a message? YES NO

Guardian/Power of Attorney: _____ Relationship _____ Phone: _____

Emergency Contact: _____ Relationship _____ Phone: _____

PSYCHIATRY

Current Psychiatrist: _____ City/Address/Phone: _____

Past Psychiatrist/How long ago: _____ City/Address/Phone: _____

Reason for Changing: _____

Current Concerns: _____

Medications: _____

Primary Physician: _____